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Dr. Shankara Chetty treated 8,000 COVID patients with no hospitalizations

How Dr. Shankara Chetty has treated 8,000 COVID patients many of whom were critical, with no hospitalizations, no need for oxygen, no deaths

<https://rumble.com/vr8m7s-dr.-s.-chetty-interview-the-omicron-all-you-need-to-know.html>

Dr. Shankara Chetty interview excerpts, December 22, 2021

Question: Can you figure out who has Omicron and who has Delta?

The symptoms are very different. With Delta we are seeing the same severity of initial presentation. We are seeing the respiratory symptoms. We are noticing the deterioration on the 8th day which can be severe. And so the presentation of the two different variants is, it's possible to tell them apart clinically. With the Omicron variant we are noticing that patients don't have respiratory symptoms per se. They have a sore throat on the first day which by the second or third day resolves completely. But the overriding symptom they present with is fatigue, headaches. So those are the main symptoms that we are seeing with Omicron. So when I get a patient without respiratory symptoms and has overriding fatigue and severe headaches then I'm suspicious that's an Omicron variant ... There's headache, fatigue, some body aches and a transient sore throat. ... They know they have a flu-like illness but the symptoms are not typically respiratory.

Question: What do you do with your patient when you diagnose Omicron variant?

Omicron is a mild variant. There is no reason to panic. We treated initially like a viral infection like I've done with all the other variants in the different waves. Add we watch for resolution. We know that there's a worsening on the 8th day triggered by hypersensitivity. With the Omicron variant we've seen very mild hypersensitivity reactions In very few patients on that 8th day and I think that's the reason it's a mild variant. So it's the hypersensitivity leading to hyper inflammation that is responsible for the mortality and the morbidity of a particular variant. Its ability to cause allergy or to trigger that response. And I think with all the mutations in the spike protein, the spike protein has

become less allergenic. So yes with every patient we still watch for the eighth day. There are some few who noticed some slight reaction and we treat it accordingly but other than that, in all the patients I've seen the illness that is caused by Omicron is pretty mild and relatively self-limiting. So symptomatic treatment tends to suffice.

Question: Can you summarize what you do at the first symptoms and what you do on the 8th day when the 8th day intervention is warranted?

What we noticed was that there was a change occurring on that 8th day. So I realized that we are dealing with a biphasic illness. The two phases are nonlinear and unrelated to each other so the severity of the first phase does not dictate the severity of the second. Now the first phase is a viral illness. That presentation changed with each variant. It incorporated gastrointestinal symptoms in the second wave. so we treat the first phase of the illness as a self-limiting viral illness And it's treated relatively symptomatically. A majority if not all patients show signs of recovery by about the 5th or 6th day. In a majority. Some are a lot quicker than that. So it's generally symptomatic treatment and of course we plot the first day of illness so we can predict the 8th day and when we might find a start to the second part of this illness. In doing this our aim is to get the patient to the 8th day almost completely recovered from the viral phase. So that is the initial aim and on the 8th day those that have allergy to spike protein can trigger a hypersensitivity reaction. That reaction if left untreated spirals into hyper inflammation and hypercoagulation. So predicting the 8th day, advising patients or educating patients about not discounting any symptoms on that day is vitally important. And if patients come back on that eighth day then the modality of that treatment is the suppression of a severe hypersensitivity reaction which requires a toolbox of treatment that includes antihistamines, montelukast, aspirin for the clotting disorders, H2 blockers like cimetidine for gastrointestinal symptoms, and a healthy dose of steroids to suppress the reaction timeously. Each patient is slightly different so from the eighth day it requires a little bit of management. So we do biomarkers to have a look at whether we're turning this around, how severe the reaction is. Treatment is adjusted accordingly.

Question: What about your protocol for the first days of infection?

In the first days, I tend to treat symptomatically. So if a patient has body aches and pains and fever and that kind of thing, we put them on something to suppress that. Generally we use anti-inflammatories. My choice is either naproxen or celecoxib. I've tried colchicine but strangely here I see a lot of gastrointestinal side effects with colchicine. So those with severe symptomatic body aches and pains tend to get an anti-inflammatory. We generally start an antihistamine for those that have runny noses and things like that. So it's very symptomatic treatment. For those having symptoms indicating a higher viral load, those that have severe aches and pains, high fevers, spiking temperatures, look ill, I generally add plasmoquine, at 200 twice a day for 5 days as an antiviral. But that is used in patients few and far between. It is only used in those who look like they are not going to resolve by the 7th day that get a course of plasmoquine added to their treatment. The rest of the treatment is in anticipation of what might occur on the 8th day. So we add montelukast to try to stabilize mast cells, quercetin in some, we tend to use vitamin D3 and zinc to try and prevent an immune reaction that's out of sync with what's required. So the entire ambit of treatment in the first phase is symptomatic and of course trying to prepare for what might happen on the 8th day. Those who have high viral loads we just add plasmoquine to their treatment and that seems to work in stopping that viral replication.

Question: So what about Ivermectin, hydroxychloroquine?

Plasmoquine is a derivative of hydroxychloroquine. I found it is an antiviral it works really well but I limited to those who actually require it, seeing that it's self-limiting in the first phase. When it comes to ivermectin I've found more benefit with ivermectin in the prophylactic use where once weekly dose, and I've found more benefit of ivermectin post eighth day. Ivermectin was initially used in the treatment of filarial illness. The treatment of filarial illness causes what we call an eosinophilic lung inflammation. The dead parasites trigger an allergic reaction in the lung. And ivermectin is shown to clear the eosinophils from the lung quite effectively. There are the medications in that group like diethylcarbamazine citrate, niclosamide or nitazoxanide that are known to clear eosinophils from the lung. Eosinophils in the lung are an indication of, are usually there because of an allergic response. So my choice of ivermectin was simply that. when a patient post

8th day starts showing saturation issues or lung issues, then I start ivermectin. However ivermectin has since been superseded by, I think, the understanding of the pathology that occurs after the 8th day. And I found that the toolbox of medications that I use gives me far more benefit timeously and clinically than Ivermectin has.

Question: In the absence of early treatment is your analysis similar, is it the same, that people should not fear Omicron even if they don't have access or they don't know about early outpatient treatment?

When we talked early outpatient treatment, understanding the pathogenesis of covid and how it causes pathology is vitally important in how we choose to treat it. Yes there's been a lot of [medications] that have shown benefit but have become very controversial simply because we attempt to use them what we call "off label." Yet they are safe and effective. Now the controversy around those medications has created a lot of issues with access to them. However if you look at the pathogenesis of covid, We don't need unusual off-label medications to treat it. What we're dealing with is a simple allergic reaction on the 8th day. And preceded by a self-limiting viral illness. So the run-of-the-mill medications work, and those are not banned in a lot of countries. A lot of the medications that will treat this are actually available over-the-counter. On the 8th day when you have an allergic reaction you need antihistamines, you need montelukast, you need a dose of steroids. These are easily available. What needs to be understood, the world is trying to treat a Covid pneumonia. Now covid pneumonia is an infective pneumonia caused by a viral infection. But what we see is not a covid pneumonia. What we see is a hypersensitivity pneumonitis. It's a severe allergic reaction in the lung itself. And so the treatment differs considerably. Those still trying to treat a covid pneumonia with antivirals are still failing, whereas those who realize we're dealing with an inappropriate immune response on that 8 day are succeeding. In the end, the antihistamines, the steroids, montelukast, they all show great benefit. In fact in my practice I found that the quickest reversal of hypoxia comes with the use of antihistamines. I've had patients with 70% oxygen saturation that improved to 85% Within a matter of 4 hours when I added a strong antihistamine. No other medication has shown that remarkable benefit. So I think it's not a matter of using drugs off label. It's a matter of

changing the label. The label is no more “covid pneumonia.” It should be “hypersensitivity pneumonitis.” And if it is hypersensitivity pneumonitis all the medications that are used are completely on the label and can be easily readily available to patients. So I think early treatment is vitally important and should be accessible to patients if they know and understand exactly what is happening with this virus. We don't try to avail ourselves of treatments that are controversial and difficult to come by.

Question: Can you confirm that hospitalization is not needed in the vast majority of cases if patients have access to and receive such early treatment?

In the work that I have done I'm approaching close to 8,000 patients now. These patients are patients that I've seen physically myself, and a lot of them presented to me critically ill. It doesn't mean that because we do outpatient Care that the patients who present to us are not that ill. I've seen patients presenting me with saturations of 40%. They were brought in by an ambulance on a stretcher with a drip on oxygen. I continued their home care with daily monitoring and a phone call to make sure that medicines were adjusted. And in all the 8,000 patients I've had, I have had no deaths. I've had no hospitalizations. And I've had no need to have oxygen in my practice. The timeous reversal of hypoxia negates the need for any oxygen supplementation. You can't put a band-aid on an infected wound and claim that it looks better. You have got to address the problem. And if the problem is a hypersensitivity reaction in the lung itself, addressing that problem shows remarkable timeous Improvement. So early outpatient treatment has the ability to not only to stop all the hospitalizations, But to curb all the mortality and morbidity that we've seen. My experience can be shared by many doctors around the world. I've done a lot of training for doctors in Malaysia and Singapore and now in Sri Lanka and in India, and I've had feedback from quite a few doctors who have used this perspective to treat. Remember we're not talking specific medication. We're talking a perspective and so a doctor who understands the perspective can choose what they would like to use to treat it. No doctors treat a bee sting in the same way, Yet the methodology if understood correctly allows you a toolbox of treatment. All these doctors that I've spoken to who have used this modality of treatment have had exactly the same results. No hospitalizations, no deaths, and no need for oxygen even in

critically ill patients. So claiming that hospitals are the only place that can solve this problem I think is a fallacy. It's created a lot of controversy from the start of the pandemic. Just to put some context, if you came to me with a bee sting with a very severe allergic reaction, your face was swollen, your throat was closing and I said there's no treatment for this. You're going to have to isolate yourself at home. But if you feel that you can't cope, you're going to have to get yourself to a hospital. Now after a few days of trying to deal with this on your own, because hospital is really a kind of daunting place to want to visit, you realize that you need hospitalization. But by that time you have caused organ damage. Your heart has been damaged your kidneys have been damaged and that kind of thing. And when you present to hospital you are a critically ill patient now. And of course the doctor in the hospital has no clue that you were stung by a bee and this was triggered by an allergic response. So he's doing everything to save your life working blind. And I think that is where the failure in hospitals is. They have kept chasing the bee, not realizing that you are allergic to its sting. And so I think early treatment is actually what is required. Hospitalization should be reserved for those patients with severe comorbidities that might have side effects or adverse effects from medications that are routinely used. And Hospital should be used as a tertiary measure to lean on in those difficult to handle cases. I've been forced to do ICU on an outpatient basis simply because of the fear of hospitalization. And so if ICU treatment can be done at home and show such remarkable results I wish I had my colleagues support me in this and give me a hospital bed every now and then with the same perspective and not change my treatment as soon as they get their hands on my patients.

Documentation and discussion of Dr. Chetty's protocol:

“Early Treatment of the Inflammatory Stage of COVID-19 and its rationale,”
Bastian, Elizabeth; Karrow, Niel A.; Halgas, Ondrej; Nakatsu, Kanji
<https://zenodo.org/record/5033246#.Yc8xfWjMKU1>